Appendix 11
Sample Prior Authorization Specialized Medical Vehicle Attachment (PA/SMVA)

Mail To:
EDS
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/SMVA

Prior Authorization Specialized Medical Vehicle Attachment

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

Recipient Information

① Last Name	② First Name	③ Middle Initial	④ Medicaid ID Number	⑤ Age
Recipient	Ima	A	9876543210	25

Provider Information

⑥ Performing Provider's Name	⑦ Performing Provider's Medicaid Provider Number	⑧ Performing Provider's Telephone Number
I. M. Provider	12345678	(555) 555 - 5555

A. Do you have a current Physician Certification, signed by a physician, physician assistant, nurse midwife, or nurse practitioner documenting the recipient's need for SMV transportation on file for this recipient?

☐ Yes ☐ No

B. Please attach a copy of the prescription for trips that exceed the SMV mileage limit signed and dated by a physician, physician assistant, nurse midwife, nurse practitioner, dentist, optometrist/optician, chiropractor, podiatrist, HealthCheck agency, or family planning clinic.

The provision of services which are greater than, or significantly different from, those authorized may result in non-payment of the billing claim(s).

C. MM/DD/YYYY (Date) — I. M. Provider (Requesting Provider's Signature)